Kansas Department on Aging

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLE	ובט
					c	
		N046086	B. WING		01/2	0/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
BENTON I	HOUSE OF PRAIRIE VILI	AGE 2700 SOM	ERSET DRIVE			
DENTON	1000E OF TRAINE VIEW	PRAIRIE V	ILLAGE, KS 6	6206		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS		S 000			
	an abbreviated surveinvestigation 79466 a	s represent the findings of y and complaint the above named assisted and 1-15-15 and 1-20-15.				
S3130 SS=F	26-41-203 (d) Specia	I Care Services	S3130			
	an assisted living facifacility may choose to exceed the facility's criteria and who have care section of the fact the administrator or of the following condition (1) Written policies a developed and are im of the special care see (2) Admission an effect that identify the specific clinical needs served. The medical oprovider's progress admission to the specifacility. (3) A written order frootstained for admission (4) The functional cap	and procedures are applemented for the operation ction or facility. It discharge criteria are in diagnosis, behavior, or sof the residents to be diagnosis, medical care notes, or both shall justify cial care section or the ma medical care provider is in. Deacity screening indicates				
	and programs offered or facility. (5) Before the reside special care section of resident's legal repres writing, of the availab that are specific to the (6) Direct care staff at care section or facility	d benefit from the services by the special care section Int's admission to the or facility, the resident or sentative is informed, in le services and programs e needs of the resident. The present in the special of at all times. It to the special care section				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		N046086	B. WING		C 01/20/2015
NAME OF D	ROVIDER OR SUPPLIER	CTDEET VI	DDRESS, CITY, STA	TE ZIR CODE	
NAME OF T	NOVIDEN ON 3011 LIEN		MERSET DRIVE	II., ZII GODE	
BENTON	HOUSE OF PRAIRIE VILI	_AGE	VILLAGE, KS 6	6206	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
S3130	Continued From page	: 1	S3130		
	training program relatives residents to be served completion of the trainemployee's personne (8) Living, dining, activate provided within the except when resident dining, activity, and resection of the facility. (9) The control of exit	ning is maintained in the			
	This REQUIREMENT by: KAR 26-41-203(d)	is not met as evidenced			
	22 residents residing sample included 3 res reviews. Based on refor 2 (#1, #3) of 2 resimemory care unit, the ensure that before readmission to the speciality: written policied developed and impler the special care section medical care provider admission; and the reforesentatives were available services and	e administrator failed to sident #1 and #3's sial care section of the s and procedures were mented for the operation of on; a written order from a was obtained for sident's legal informed, in writing, of the			
	- Observation during accompanied by licen	tour of the facility sed staff A on 1-15-15 at			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			D 14/11/0		С
		N046086	B. WING		01/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
BENTON I	HOUSE OF PRAIRIE VILI	AGE 2700 SOME	RSET DRIVE		
		PRAIRIE V	LLAGE, KS 6	6206	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
S3130	Continued From page	2	S3130		
	memory care units. A keypadded. License census of unit 1 with 7 residents per the re	locked units designated as All doors on both units d staff A confirmed the 15 residents and unit 2 with sident roster. Stated the ned in November 2014.			
	Dementia, Hypertens	with diagnoses Alzheimer's ion, Dysphonia,			
	Degenerative Joint Disease, and Obesity. The functional capacity screen dated 10-1-14 recorded resident required physical assistance with bathing and dressing; independent with toileting, transfers and walking/mobility; and unable to perform management of medications and treatments. Usually continent of bladder. Cognition: problems with short term memory. Current problems/risks identified included: falls/unsteadiness, impaired vision, and impaired decision-making.				
	recorded services for bathing (daily), and de evening); toileting ass	sistance every 2 hours (as of ance with all aspects of			
	walking out of facility, meet his (family mem with resident while he facility. Resident redibut he/she attempted to go outside. Seroquordered for behavior.	Resident) was observed stating he/she was going to ber) outside. Staff present e/she was ambulating off rected back into building, on 3-4 different occasions are 1/4 tablet offered as Resident taken to memory ny attempt and possible			

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					C
		N046086	B. WING		01/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE	
BENTON	HOUSE OF PRAIRIE VILI	_AGE	MERSET DRIVE		
	OLIMANA DV OT		VILLAGE, KS 6		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
S3130	Continued From page	2 3	S3130		
	further attempts of eld notified via phone voi nurse B.	at 1:10 pm observed unit's common area. No opement. Family member cemail." Signed by licensed			
	lockdown unit for the	ed confusion. Was on the better half of the day. provided" Signed by			
	move from assisted li Movers are moving hi apartmentappears t	o be in pleasant mood. er resident he/she knew			
	The record lacked a r written order to transf memory care unit.	nedical care provider's er resident #1 to the			
	with administrator, lice administrative staff D moved to the memory Further confirmed the and procedures specinothing in writing was regarding the program the memory care unit resident #1; and that	confirmed resident #1 was			
	- Record review for readmission on 1-19-13 Depression, Pain, Hy				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		N046086	B. WING		C 01/20/2015
	ROVIDER OR SUPPLIER	AGE 2700 SOM	DRESS, CITY, STATERSET DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE COMPLETE
S3130	The functional capaci recorded resident req with bathing, dressing with transfers and wa with eating; and unab of medication and trea incontinent of bladder short term memory ar The negotiated service recorded services for bathing, dressing and assistance with ambu and assistance with amanagement on a da Nurses's Notes: 12-2 "Resident moved to make a licensed nurse E The record lacked a matter order to transform memory care unit. Interview on 1-15-15 administrative staff Dunits are locked units increased activities, lequieter environment. In their apartments ever don't have to make a hall to walk down. Stimuch easier.	ty screen dated 10-5-14 uired physical assistance if, and toileting; supervision liking/mobility; independent le to perform management atments. Frequently c. Cognition: problems with ad decision-making. The agreement dated 10-5-14 physical assistance with all aspects of toileting, no lation (uses rolling walker) Il aspects of medication ity basis. 1-14 (time unknown): the memory care unit with the insistance" Signed by Interest the signed by Interest the signed state of the	S3130		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILBING.		С
		N046086	B. WING		01/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
BENTON	HOUSE OF PRAIRIE VILL	_AGE	ERSET DRIVE		
DENTON	TOOSE OF FRANCE VIEW	PRAIRIE \	ILLAGE, KS 6	6206	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
S3130	Continued From page	e 5	S3130		
	memory care unit. St speak with the family; in writing was provide programs and service care unit specific to the The administrator faile #1's and #3's admissi section of the facility: procedures were developed the operation of the sporder from a medical for admission; and the representative was in available services and	written policies and eloped and implemented for pecial care section; a written care provider was obtained e resident's legal formed, in writing, of the			
S3171 SS=D		Care Services Standards of	S3171		
	residents by qualified acceptable standards	vices shall be provided to staff in accordance with of practice. is not met as evidenced			
	The facility reported a The sample included review residents. Bas interview for 1 (#2) of administrator failed to services shall be prov	dance with acceptable			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7.1. 20.22.110.		С
		N046086	B. WING		01/20/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
BENTON I	HOUSE OF PRAIRIE VILL	_AGE	ERSET DRIVE		
		PRAIRIE \	/ILLAGE, KS 6		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
S3171	Continued From page	9 6	S3171		
	- Record review for readmission on 1-21-13 Chronic Obstructive F Hyperlipidemia, Edem	with diagnoses Dementia, Pulmonary Disease,			
		ty screen dated 10-1-14			
	recorded resident una of medications and tre	able to perform management eatments.			
	The negotiated service agreement dated 10-1-14 recorded assistance with all aspects of medication management on a daily basis.				
	following: 8-19-14: home health buttock pressure wou as needed. 9-25-14: electrocardi monitor.	for wound care Mepilex to nd change every 3 days and ogram stat, order event or culture and sensitivity.			
		at 3:30 pm with licensed corders lacked a physician			
		services shall be provided ed staff in accordance with			
S3200 SS=E	26-41-205 (d) (1-2) Fa Medications	acility Administration of	S3200		
		tion of resident 's lity is responsible for the sident 's medications, the			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7. BOILDING		С
		N046086	B. WING		01/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		2700 SON	IERSET DRIVE		
BENTON	HOUSE OF PRAIRIE VILI	LAGE PRAIRIE	VILLAGE, KS 6	6206	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
S3200	Continued From page	27	S3200		
	medications and biolo that resident in accord provider's written ord of practice, and each recommendations. To shall ensure that all o (1) Only licensed nur	he administrator or operator f the following are met: ses and medication aides manage medications for responsibility. shall not administer			
	This REQUIREMENT by: KAR 26-41-205(d)	is not met as evidenced			
	The sample included record reviews. Base interview for 1 (#2) of (#5) of 3 closed recordiled to ensure that a biologicals are administrated accordance with a metorder, and profession. Findings included: Record review for record review for record review.	istered to the resident in edical care provider's written al standards of practice. esident #2 revealed with diagnoses Dementia, Pulmonary Disease,			
		ty screen dated 10-1-14 able to perform management			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLE	
		N046086	B. WING		01/2	; 0/2015
NAME OF D	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZID CODE	01/2	0/2015
		2700 SOME	RSET DRIVE	11, 211 GODE		
BENTON	HOUSE OF PRAIRIE VILL	AGE PRAIRIE VI	LLAGE, KS 6	6206		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
S3200	Continued From page	8	S3200			
	of medications and tre	eatments.				
	recorded assistance was medication managem	•				
	(MAR) for December Acetaminophen 325 r (tablets) by mouth thre lacked documentation	2014 revealed the following: ng (milligrams) 2 tabs ee times daily for pain: n of administration on				
	12-21-14 at 12:00 pm; Albuterol nebulizer treatment four times a day for 7 days for shortness of air: lacked documentation of administered on 12-21-14 at 12:00 pm; Advair Diskus 250/50 inhale 1 puff every 12 hours					
	lacked documentation 12-21-14 at 8:00 am;	21-14 at 8:00 am; th daily for atrial fibrillation: of administration on				
	days for urinary tract i	g by mouth twice a day for 7 nfection: lacked ninistration on 12-21-14 at				
		1-10-15: Cipro 250 mg tab for 7 days for urinary tract				
	following: Cipro 250 mg tab by r for urinary tract infecti of administration on 1 pm, 1-12-15 at 8:00 a 8:00 am. Documenta	mouth twice a day for 7 days on: lacked documentation -11-15 at 8:00 am and 8:00 m and 8:00 pm, 1-13-15 at tion on back of MAR stated able" for these days and				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE COMP	SURVEY
		N046086	B. WING		I	C 20/2015
	ROVIDER OR SUPPLIER	2700 SO	DDRESS, CITY, STA			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S3200	nurse A confirmed the documentation of adriconfirmed the record physician notification the Cipro as ordered For resident #2, the athat all medications a administered to the remedical care provider professional standard	at 3:24 pm with licensed above medications lacked ninistration. Further lacked documentation of that resident failed to start on 1-10-15. dministrator failed to ensure and biologicals are esident in accordance with a s's written order, and s of practice.	\$3200			
	Depression, Hypothyl Hypertension, Xeropt Allergy.	halmia, and Seasonal				
		ty screen dated 8-15-14 able to perform management eatments.				
	stated resident requir	e agreement dated 8-15-14 ed assistance with all n management on a daily				
	Tobradex ophthalmic	y physician on 8-26-14: ointment: 1/4 inch strip of es for 2 weeks then stop.				
	while awake in both e	use 1 drop every 2-3 hours yes. % use at bedtime in both				
	Review of Medication	Administration Record				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					c	;
		N046086	B. WING		01/2	0/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BENTON I	HOUSE OF PRAIRIE VILI	LAGE	RSET DRIVE LLAGE, KS 6	6206		
	OUR MAR DV OT		, , , , , , , , , , , , , , , , , , ,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
S3200	Continued From page	e 10	S3200			
	(MAR) for September following: Levothyroxin 25 mcg by mouth daily for hyy documentation of adm 9-5-14. Genteal Gel 0.3% use Xeropthalmia: lacked administration at 8 pn Tobradex ophthalmic ointment into both eye then stop for inflammed documentation of adm 9-1-14, 9-11-14 and 9 Refresh Celluvisc 1% indication) use 1 drop hours while awake: laadministration on 9-1-9-2-14 at 6 am; 9-3-1 9-7-14 at 6 am; 9-8-1 am. The record further regarding reason medication of administration of	(micrograms) 1 tab (tablet) cothyroidism: lacked ministration at 6 am on e in both eyes at bedtime for documentation of n on 9-7-14. cointment 1/4 inch strip of es at bedtime for 2 weeks ation: lacked ministration at 8 pm on 0-12-14. cophthalmic drops (no on in both eyes every 2-3 tacked documentation of 1-14 at 6 am; 3 pm and 6 pm; 4 at 6 am; 9-6-14 at 6 am; 4 at 6 am; and 9-9-14 at 6 er lacked documentation dications not administered. at 2:35 pm with licensed er above medications lacked ministration as listed and entation as why not administrator failed to ensure and biologicals are esident in accordance with a r's written order, and				
S3210 SS=D	26-41-205 (e) (f) Med Standing Orders	lis of practice. lication Verbal Orders and s. Only a licensed nurse or	S3210			
	• •	·				

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, JIP CODE 2700 SOMERSET DRIVE BENTON HOUSE OF PRARIE VILLAGE PRARIE VILLAGE, KS 86208 PROVIDER'S REPLAN OF CORRECTION (PACH) DESCRIPTION (MIST OF PRACEDOR BY PLAI, REGULATORY OR SUPPLIER STAGE SUMMANY STATEMENT OF DEPTICENCES PRARIE VILLAGE, KS 86208 PROVIDER'S PLAN OF CORRECTION (PACH) DEPTICATION SHOULD BE PREFIX TAG CROSS-REPRENENCED TO HEAP PROPRIATE S3210 Continued From page 11 a licensed pharmacist may receive verbal orders for medication from a medical care provider. The licensed nurse shall ensure that all verbal orders are signed by the medical care provider within seven working days of receipt of the verbal order. (f) Standing orders on freatments formulated and signed by the reciclations shall not include orders for the administration of schedule If medications or psychopharmacological medications and relations or psychopharmacological medications. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(e) The facility reported a census of 64 residents. The sample included 3 residents and 3 closed record reviews. Based on record review and interview for 1 (#3) of 3 sampled residents, the administrator failed to ensure the licensed nurse ensured that all verbal orders. Findings included: - Record review for resident #3 revealed admission on 1-19-13 with diagnoses Depression, Pain, Hypetrension, Hypothyroidism, Hypertipidemia, Hypercholesterolemia, Gastroscophageal Reflux Disorder and Edema.		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE 2700 SOMERSET DRIVE PRAIRIE VILLAGE PRAIRIE VILLAGE, KS 66206 SUMMAND STATEMENT OF DEPICIENCIES (KA), ID SUMMAND STATEMENT OF DEPICIENCIES (KA) HO PREDIX AND STATEMENT OF DEPICIENCIES (KA) HO PREDIX TAG CONTINUED FOR MANY STATEMENT OF DEPICIENCIES (KA) HO PREDIX TAG CROSS REFERENCE TOWN OF STATEMENT OF DEPICIENCIES S3210 Continued From page 11 a licensed pharmacist may receive verbal orders for medication from a medical care provider. The licensed nurse shall ensure that all verbal orders are signed by the medical care provider within seven working days of receipt of the verbal orders (f) Standing orders of Only a licensed nurse shall make the decision for implementation of standing orders for specified medications and treatments formulated and signed by the resident's medical care provider. Standing orders of medications shall not include orders for the administration of schedule II medications or psychopharmacological medications. This RECUIREMENT is not met as evidenced by: KAR 26-41-205(e) The facility reported a census of 64 residents, The sample included 3 residents and 3 closed record reviews. Based on record review and interview for 1 (#3) of 3 sampled residents, the administrator failed to ensure the licensed nurse ensured that all vehal orders are signed by the medical care provider within seven working days of receipt of the verbal order. Findings included: - Record review for resident #3 revealed admission on 1-19-13 with diagnoses Depression, Pain, Hypertension, Hypothyriodism, Hyperlipidemia, Hypertension, Hypothyriodism, Hyperlipidemia, Hypercholesterolemia,	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	EIED
BENTON HOUSE OF PRAIRIE VILLAGE (MA) D			N046086	B. WING		1	
CALLING CALL	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
S3210 Continued From page 11 S3210 S32	BENTON I	HOUSE OF PRAIRIE VILI	LAGE		6206		
a licensed pharmacist may receive verbal orders for medication from a medical care provider. The licensed nurse shall ensure that all verbal orders are signed by the medical care provider within seven working days of receipt of the verbal order. (f) Standing orders. Only a licensed nurse shall make the decision for implementation of standing orders for specified medications and treatments formulated and signed by the resident 's medical care provider. Standing orders of medications shall not include orders for the administration of schedule II medications or psychopharmacological medications. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(e) The facility reported a census of 64 residents. The sample included 3 residents and 3 closed record reviews. Based on record review and interview for 1 (43) of 3 sampled residents, the administrator failed to ensure the licensed nurse ensured that all verbal orders are signed by the medical care provider within seven working days of receipt of the verbal order. Findings included: - Record review for resident #3 revealed admission on 1-19-13 with diagnoses Depression, Pain, Hypertholesterolemia, Hyperthipidemia, Hypertholesterolemia,	PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETE
The functional capacity screen dated 10-5-14 recorded resident unable to perform management of medication and treatments.	S3210	a licensed pharmacis for medication from a licensed nurse shall eare signed by the messeven working days of (f) Standing orders. Or make the decision for orders for specified medicate provider. Standing shall not include ordes schedule II medication psychopharmacological shall not include ordes schedule II medication psychopharmacological. This REQUIREMENT by: KAR 26-41-205(e) The facility reported as the sample included record reviews. Base interview for 1 (#3) of administrator failed to ensured that all verbas medical care provider of receipt of the verbas. Findings included: Record review for readmission on 1-19-13 Depression, Pain, Hy Hyperlipidemia, Hyper Gastroesophageal Recorded resident under the sample included recorded resident under the functional capacity recorded resident under the sample included recorded resident under the functional capacity recorded resident under the sample for the samp	t may receive verbal orders medical care provider. The ensure that all verbal orders dical care provider within of receipt of the verbal order. Only a licensed nurse shall implementation of standing nedications and treatments diby the resident 's medical ing orders of medications are for the administration of ins or call medications. The is not met as evidenced The census of 64 residents. The residents and 3 closed and on record review and and a sampled residents, the ensure the licensed nurse all orders are signed by the rewithin seven working days all order. The resident #3 revealed with diagnoses pertension, Hypothyroidism, incholesterolemia, eflux Disorder and Edema. The resident #3 revealed and Edema. The resident #4 is revealed and Edema.	S3210			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		N046086	B. WING		01/20/2015	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
BENTON HOUSE OF PRAIRIE VILLAGE 2700 SOMERSET DRIVE PRAIRIE VILLAGE, KS 66206						
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	(EACH CORRECTIVE ACTION SHOULD BE COMPLÉTE CROSS-REFERENCED TO THE APPROPRIATE DATE	
S3210	Continued From page 12		S3210			
	recorded assistance we medication managem Record review of vert following: 12-15-14: May crush metoprolol and pantor The order lacked a phologonal process of the signature. For resident #3, the lift the verbal order was signature.	ent on a daily basis. pal orders revealed the all medications except prazole.				